Premier Pediatrics of Sumter, LLC

380 W Wesmark Blvd, Bldg B • Sumter SC 29150 • (803) 607-9430 Fax (803) 607-9431

Patient Application

Patient Information (Please list children oldest to youngest)

Child's (Legal) Name: First	MI	Last	Sex	Date of Birth	Social Security Number (Required)
			M F		
Child's (Legal) Name: First	MI	Last	Sex	Date of Birth	Social Security Number (Required)
			M F		
Child's (Legal) Name: First	MI	Last	Sex	Date of Birth	Social Security Number (Required)
			M F		
Child's (Legal) Name: First	MI	Last	Sex	Date of Birth	Social Security Number (Required)
			M F		

Next of Kin - Father (Circle One) Birth - Stepfather - Adoptive Father - Foster - Legal Guardian (proof required)

Father's Name: First	MI	Last	Date of Birth	Social Security Number (Required)

Address			
Street	City	State	Zipcode

Primary Phone Number	Occupation	Email

Next of Kin - Mother (Circle One) Birth - Stepmother - Adoptive Mother - Foster - Legal Guardian (proof required)

Mother's Name: First	MI	Last	Date of Birth	Social Security Number (Required)

Address			
Street	City	State	Zipcode

Primary Phone Number	Occupation	Email

Insurance Information (Please list all insurances that apply to the patients listed above)

Insurance Company (Payor Name}	Insurance ID

Subscriber's Name: First	MI	Last	Policy applies to which patients? Circle all or list patient names
			All

Insurance Company (Payor Name}	Insurance ID

Subscriber's Name: First	MI	Last	Policy applies to which patients? Circle all or list patient names
			All

Billing Information (Bills will be sent to Insurance Subcriber unless you indicate a different address below)

Name: First	MI	Last	Sex	Date of Birth	Social Security Number (Required)
			M F		

Address			
Street	City	State	Zipcode

Primary Phone Number	Secondary Phone Number	Email

Additional Persons

Please list all Persons who have permission to bring the patient in for medical care and sign a consent for any vaccine administration.

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

I hereby authorize the physician to furnish information to insurance concerning the illness/accident and hereby irrevocably assign to the doctor all payments for medical services rendered. In the event my account is placed in the hands of an attorney for collection, I agree to pay all cost and expenses including all attorney fees related to the collection thereof. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original.

Signed ______________________________ Date ______________________________

Notes: (Please add any additional information, unique circumstances (i.e. children live with different parents), etc.)